United Healthcare

December 22, 2021

Via Email: michael.boutte@la.gov
Michael Boutte
Medicaid Deputy Director
Bienville Building
628 N. Fourth St.
Baton Rouge, Louisiana 70821

Re: Request for Reconsideration of the Notice of Monetary Penalty to UnitedHealthcare dated December 16, 2021

Dear Mr. Boutte:

I am writing you about the monetary penalty that your department issued to United Healthcare Community Care Plan of Louisiana ("United") on December 16, 2021. In the penalty letter, your agency explains that United is obligated to comply with the terms of the Louisiana Department of Justice Agreement (Case 3:18-cv-00608, Middle District of Louisiana). It goes on to say that United has not complied with the Department of Justice Agreement Compliance Guide that the Louisiana Department of Health (LDH) has issued, stating in its penalty letter:

> The DOJ Agreement Compliance Guide requires UHC to have contracted with a community case management (CCM) agency by November 12, 2021, to ensure there would not be delays in CCM implementation . As of the date of this Notice, UHC has not entered into a contract with the CCM agency.

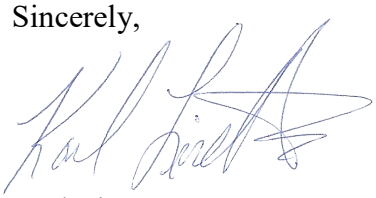
Your agency issued a $165,000 fine to United, which is based on a penalty of $5,000 per day from November 12, 2021, to the date of the penalty letter was issued on December 16, 2021.

Please accept this letter as United's appeal of the monetary penalty. United has a contract with an LDH-approved community case management agency. The contract is attached hereto, and labeled as Attachment A. United notified the LDH that it had entered into the agreement through an email notice on November 22, 2021. It later sent the LDH a copy of the agreement on November 29, 2021. Copies of those email communications are attached, and labeled as Attachment B.

Because United had a contract in place as of the date of the December 16, 2021 penalty letter, we respectfully ask that the LDH set aside the $165,000 penalty. If the LDH still desires to maintain a fine against United, then we ask that the penalty amount be reduced. The LDH's penalty letter is based on the allegation that United did not have an executed contract on December 16, 2021, which as explained above, is inaccurate. United has had an executed contract since November 22, 2021. The LDH's compliance guide required an executed contract by November 12. So any penalty of $5,000 per day should accrue from November 13 to November 22, for a total of nine days, and a fine of $45,000.

I thank you for considering our position on this matter. Please contact me if there is any additional information that I can provide that would help the LDH to evaluate these requests.

Sincerely,



Karl Lirette
Chief Executive Officer

Enclosure

ATTACHMENT A

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding (hereinafter referred to as "MOU" or "Agreement") is made and entered into by Merakey Pennsylvania ("Provider" or "Agency") and United Behavioral Health ("Optum"),[1] on behalf of itself and its subsidiaries and affiliates (together, the "Parties"). The purpose of this MOU is to set forth roles, responsibilities and requirements of the parties in providing certain community case management services (as described in this MOU). The effective date of this MOU is January 1, 2022.

WHEREAS, the parties seek to provide a specialized community case management ("CCM") program to assist in diverting identified members from nursing facilities and/or to facilitate the transition from nursing facilities into the community to address services gaps whereby nursing facilities are not best suited to serve certain adults with serious mental illness and instead seeks to serve them in the most integrated setting appropriate to their needs; the CCM program will be for the Target Population as (defined below) (the "CCM Services");

WHEREAS, Agency is a provider of mental health services, including a community case manager that meets the qualifications established by The Louisiana Department of Health ("LDH") and the CCM Services will be consistent with the agreement between LDH and the Department of Justice ("DOJ") to provide case management related to mental health services to adults with serious mental illness (Appendix A, described below under "Provider Role and Responsibilities");

WHEREAS, the UnitedHealthcare Community Plan of Louisiana ("MCO") is Medicaid plan offered in Louisiana and Optum is the behavioral health and case management administrator performing administrative services on behalf of the MCO;

WHEREAS, Provider will provide these CCM Services to MCO members and Optum will administer these services on behalf of the MCO;

WHEREAS, the MCO shall maintain ultimate responsibility for ensuring case management needs of the target population are met by community case managers/agencies and community case managers satisfactorily complete required activities;

WHEREAS, the CCM Services and processes shall be individualized and person-centered, reflecting the member's unique strengths, needs, preferences, experiences and cultural background. The CCM Services will be comprehensive, culturally competent and of sufficient intensity to ensure community case managers are able to identify and coordinate services and supports to assist members with obtaining good health outcomes, achieve the greatest possible degree of self-management of disability and life

[1] United Behavioral Health, operating under the brand name Optum.

SECTION 1
SCOPE OF SERVICES

1.1 Target Population. The Target Population includes:

A. Medicaid-eligible individuals over 18 with SMI currently residing in a nursing facility and those individuals who have transitioned from a nursing facility and are referred for case management by a My Choice Louisiana transition coordinator.

B. Individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review ("PASRR") Level II evaluation of nursing facility placement during the course of this Agreement, or have been referred within two years prior to the effective date of this Agreement.

C. Excludes those individuals with co-occurring SMI and dementia where dementia is the primary diagnosis.

SECTION 2
PROVIDER ROLE AND RESPONSIBILITIES

2.1 Duties of Provider. Provider will provide clinically appropriate CCM Services in accordance with the *Department of Justice Agreement Compliance Guide*, Subsections VIII only, attached hereto as **Appendix A,** including, but not limited to the following:

A. Provider will engage members at least sixty (60) days prior to a member discharge from a NF with an option to engage earlier if recommended by the LDH Transition Coordinator and will provide at least four (4) face-to-face contacts in this time, including at least two (2) in the last thirty (30) days before transition from the NF

B. For Diverted members, Provider will ensure the CCM Services being within one (1) business day of referral from the MCO;

C. The CCM initial assessment will occur within 4 business days of referral, and will also have a reassessment and updated plan of care made every ninety (90) days; and

D. Provider will provide frequent and ongoing contacts with members who are being transitioned or diverted.

2.1.1 Provider shall be qualified by law and have the capacity to provide such services. Provider shall maintain, and demonstrate upon request by Optum, that the Provider is licensed to provide behavioral health services in the state where they practice, and that Provider is in compliance with all other applicable Federal and State regulations. Provider further warrants that Provider holds and maintains in full force and effect sufficient malpractice insurance according to state mandated levels of coverage for applicable services to be rendered by Provider.

2.1.2 Provider shall abide by all applicable operating policies and procedures of Optum, as well as the "Standard Operating Procedures" (the "SOP") developed by and between MCO, other MCOs and LDH to meet the requirements of provider CCM Services and which will be given to Provider as soon as practicable. Provider specifically acknowledges and agrees to the following:

A. Provider shall ensure that a valid consent for disclosure form is signed by the assigned Optum member receiving behavioral health services from Provider in order to permit Optum, or its designee, to review claims and treatment records related to the services provided by Provider under this MOU.

B. Provider shall maintain and provide to Optum or any applicable state or federal regulatory agencies all records relating to services provided to each member as required by state and federal law. Such records shall be retained by Provider for either a period of not less than ten (10) years following the provision of behavioral health services or such greater length of time Provider may be required to maintain member records under applicable state or federal law.

C. In order to perform any utilization management and quality improvement activities, Optum shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by Optum, such access shall be given at the time of the audit. If requested by Optum, Provider shall provide copies of such records free of charge. During the term of this Agreement, Optum shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

D. Provider will maintain records consistent with the terms outlined in the "Record Keeping" section of the SOP.

E. It is Provider's responsibility to obtain any Member's consent in order to provide Optum with requested information and records or copies of records and to allow Optum to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

F. Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from Optum or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

G. This section shall not be construed to grant Optum access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives, including but not limited to, the National Committee for Quality Assurance ("NCQA"), have access to such records in accordance with applicable laws and requirements.

H. With the exception of non-covered services delivered to the patient, which the patient has been informed of the non-coverage and has agreed in writing to continue services, ***Provider shall in NO event***, including, but not limited to insolvency of Optum, bill, charge or collect

any form of payment from the member for covered behavioral health services provided by Provider pursuant to this MOU.

I. Provider will meet the requirements outlined in Appendix C to this MOU.

2.2 Conflict of Interest: The Parties agree to ensure that Provider and Provider's staff and managers do not have a conflict of interest between any direct care activities and any CCM Services responsibilities. Provider agrees that for its CCM Services program it will not utilize the same staff that it utilizes for its direct care services being provided to members in Optum's behavioral health programs in Louisiana, including maintaining a separate management and reporting structure for the CCM Services and for its Assertive Community Treatment ("ACT") program and/or other similar behavioral health programs and/or services, including but not limited to staff oversight, performance, and support. Provider will maintain appropriate firewalls between these different programs. Provider will not directly and solely refer a patient for whom it is providing CCM Services to its own direct care/treatment services and instead will seek to honor a member's freedom to choose providers and will offer members an array of provider options and services as needed, which may include, but will not only include services provided by Provider. Provider will utilize the Freedom of Choice form(s) (Appendix B) and will require execution by member and/or an authorized representative for services. Optum will provide ongoing monitoring to ensure there is no conflict of interest in these circumstances.

SECTION 3
PAYMENT AND FEES

3.1 Fees. Agency will receive cost reimbursement for its provision of CCM Services. The costs to be reimbursed will be submitted on a monthly invoice reflecting Agency's total costs of expense for the CCM Services, including but not limited to, staff salary. MCO will pay 1/4 of that total cost (and 3 other MCOs will pay the remaining 3/4).

3.2 Invoicing: Provider will submit invoices via email to Tanisha Hannon, Associate Director of Finance at tanisha.hannon@optum.com, or anyone delegated by Tanisha Hannon, on a monthly basis. Provider must complete and submit its monthly invoicing by the 10th of each month.

Provider must track and submit the following: Name, Date of Birth (DOB) and Social Security Number for members receiving the CCM Services. In addition, Provider will submit appropriate supporting documentation for all CCM Services rendered.

SECTION 4
MISCELLANEOUS

4.1 Security Measures. Provider shall maintain a comprehensive security program under which Provider documents, implements and maintains the physical, administrative, and technical safeguards necessary to protect the confidentiality, integrity, availability, and security of Optum members, which also complies with applicable law and/or regulations. Provider shall maintain written security management policies and procedures to identify, prevent, detect, contain, and correct violations of measures taken to protect the confidentiality, integrity, availability, or security of Optum member information. Such policies

and procedures shall: (a) assign specific data security responsibilities and accountabilities to specific individual(s); (b) include a formal risk management program which includes periodic risk assessments at least annually to ensure continued compliance with obligations imposed by Law or contract; and (c) provide an adequate framework of controls that safeguard Optum member information.

4.2 Notices. Provider shall notify Optum within ten (10) days of knowledge of any of the following:

A. changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
B. action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government or applicable accrediting or regulatory agency under which Provider is accredited or regulated by or authorized to provide health care services, including without limitation, any action concerning Provider's credentialing criteria or the performance of its employees, contractors or its Group-based Providers; or any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;
C. a change in Provider's name, address, ownership or Federal Tax I.D. number;
D. indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
E. claims or legal actions for professional negligence or bankruptcy;
F. provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;
G. any occurrence or condition that might materially impair the ability of Provider to perform its duties under this Agreement; or
H. any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing; electronic mail is acceptable. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

4.3 Dispute Resolution. All disputes occurring between the parties of this MOU shall be resolved through Arbitration via the American Arbitration Association.

4.4 Termination. Either party may terminate this MOU without cause at any time by providing sixty (60) days prior written notice of termination to the other party. Upon termination of the MOU, Provider shall continue to provide covered CCM Services until the effective date of transfer of patient to another Provider. Optum reserves the right to notify members of Provider's termination, and Provider agrees to cooperate with Optum to ensure any necessary transition(s) of care.

4.5 Amendment(s). This MOU may be amended at any time by written agreement signed by both parties. This MOU shall be interpreted and governed by any and all applicable federal and state laws and regulations.

4.6 Relationship Between Optum and Provider. The relationship between Optum and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

4.7 Name, Symbol and Service Mark. During the term of this Agreement, Provider, Optum and Payor shall have the right to use each other's name solely to make public reference to Provider as a Participating Provider. Provider, Optum and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

4.8 Confidentiality. Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) Optum may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) Optum shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

4.9 Communication. Optum encourages Provider to discuss with members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with members as patients of Provider, or with Optum's ability to administer its quality improvement, utilization management and credentialing programs.

4.10 Effects of New Statutes and Regulations and Changes of Conditions. The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in Optum's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

4.11 Strict Compliance. The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be

held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

4.12 Severability. Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

4.13 Rules of Construction. In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first Optum and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

4.14 Governing Law. This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

Signature page to follow

In witness whereof, the parties hereto have caused this MOU to be executed by the dates and signatures hereinafter affixed. The persons signing this MOU on behalf of the parties represent that each has the authority to execute the MOU on behalf of the party entering this MOU. **The parties hereby acknowledge that both parties intend to be legally bound by the terms agreed upon above.**

Acknowledged and Agreed:

Rebecca Schechter
Representative for Optum
Date: 11/21/2021

Acknowledged and Agreed:

DocuSigned by:
Tinnesia Snyder
D759147FC87A427...
Representative for Merakey Pennsylvania
Date: 11/22/2021

Please complete and sign the following:

Clinician Name and License Type:
Clinician License Number:
Expiration Date:
NPI (individual):

DEA Number (MD's/RN's only): N/A
Expiration Date: N/A

Effective Date (to be completed by Optum)

Send Claims to:
[ ]
Claims Dept
P.O. Box [ ]
[ ]

Or Fax:
[ ]

Request EOBs from:

Claims Questions:

Or call:

Appendix A: Department of Justice Agreement Compliance Guide

Appendix B: Freedom of Choice Form

Member Name (First, Last Name):
Member DOB:
Member ID #:

Member Freedom of Choice Form

Member Information: I am requesting services from a provider. I understand that I have the right to choose an agency to provide services to me. I understand that I may only receive each type of service(s) from **one agency** unless my health plan makes an exception. I may change agencies if I am not satisfied with the services.

If assistance is needed with finding a provider, review the list of providers located at your health plan's website below or call your plan for assistance.

1. Aetna: https://www.aetnabetterhealth.com/louisiana/find-provider or call 1-855-242-0802 Hearing impaired TTY/TDD 711
2. Amerihealth Caritas Louisiana: http://www.amerihealthcaritasla.com/member/eng/tools/find-provider.aspxor call 1-888-756-0004; TTY 1-866-428-7588
3. Healthy Blue: https://www.myhealthybluela.com/la/care/find-a-doctor.html or call 1-844-227-8350 (TTY 711)
4. Louisiana Healthcare Connections: https://providersearch.louisianahealthconnect.com/ or call 1-866-595- 8133 (Hearing Loss: 711)
5. United Healthcare Community: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html or call 1-866-675-1607 TTY: 1-877-4285-4514

The agency that I have freely selected to deliver a services to me is:
Agency Name:
Agency Phone Number:
Agency Contact Name:
Agency Address:

By signing the form below, I understand that I have freely chosen to receive services from this agency and I acknowledge that it is my responsibility to notify my previous agency so they can coordinate my care with my new agency. I understand that I am free to choose any agency in my health plan's network. I state that this agency did not direct me to choose it for providing the services I am seeking and provided me with information regarding additional agencies that could also provide these services.

_____ _____

Member/Legal Guardian Signature Date

_____

Printed Legal Guardian Name (if applicable)

Providers Information: A Member Choice form is required prior to receiving any services. This form requires member/legal guardian signature, date, identified provider with telephone and contact name. The provider is responsible for coordinating the transition of care with the member's previous provider prior to starting service.

Appendix C: Audit and NCQA Standards

The purpose of the following grid is to specify the responsibilities of Optum and Provider with respect to Population Health Management (referred to as CCM Services in the MOU). Provider agrees to be accountable for all responsibilities delegated by Optum and will not further delegate any such responsibilities without prior written approval by Optum's Authorized Representative. Optum retains all functions of Population Health Management not specified in the following as a responsibility delegated to Provider.

Delegation Oversight Audits and Reporting

Optum will perform audits at least annually to evaluate Provider's delegated status. Audits may include policies and procedures and other documented processes, reports, member materials, and case records. Provider will provide reports at least semi-annually as specified in Exhibit B, below.

Failure to Perform Delegated Activities

In the event there are deficiencies identified in the audit or through reports, Provider will provide to Optum a specific Improvement Action Plan. If Provider is not able to comply with the Improvement Action Plan within the specified time frame, Optum may revoke Provider's delegated status that the Improvement Action Plan was intended to correct.

Member Experience and Performance Data

Optum is responsible for providing member experience and clinical performance data to Provider, when requested and available, and relevant to members served by Provider. Such requests must be submitted in writing to the designated Optum Quality Improvement staff whose name and contact information will be delivered to Provider upon execution of this agreement.

Population Health Management **2022 NCQA Health Plan Standards**	**Provider Responsibility**	**Optum Responsibility**
PHM 1 Element B: Informing Members: The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate. 2. How to use program services. 3. How to opt in or opt out of the program.	X	

ATTACHMENT B

Kellogg, Alden

From:	Zerangue, Stacie L
Sent:	Monday, November 22, 2021 4:25 PM
To:	Candace Grace
Cc:	Ann Darling; Robyn McDermott; Cordelia Clay; Zerangue, Stacie L
Subject:	DOJ CCM Executed Agreement

I just wanted to advise you that UHC has an executed agreement with Merakey for the CCM program. Please let me know if additional information is needed. Happy Thanksgiving.

Stacie L. Zerangue, L.C.S.W.
Executive Director of Behavioral Health
(225) 284-7744

Kellogg, Alden

From:	Zerangue, Stacie L
Sent:	Monday, November 29, 2021 3:25 PM
To:	Kelley Francis; Thibodeaux, Nicole D; UHC Louisiana Compliance Mailbox; UHCLACompliance; Calderon-Abbo, Jose; Silver, Nanette D
Cc:	Megan Davis Fontenot; Candace Grace; MCOCommunications
Subject:	RE: UHC community case management agencies contract - PAST DUE
Attachments:	Merakey PA_LA_Optum_ MOU CCM Executed.pdf

I apologize. I misread and sent you an email advising we had an executed agreement. Please see attached.

From: Kelley Francis <Kelley.Francis@LA.GOV>
Sent: Monday, November 29, 2021 3:09 PM
To: Thibodeaux, Nicole D <nicole_thibodeaux@uhc.com>; UHC Louisiana Compliance Mailbox <uhclacompliance@uhc.com>; UHCLACompliance <UHCLACompliance_DL@uhc.com>; Calderon-Abbo, Jose <jose.calderonabbo@optum.com>; Silver, Nanette D <nanette_silver@uhc.com>; Zerangue, Stacie L <stacie.zerangue@optum.com>
Cc: Megan Davis Fontenot <Megan.Davis@LA.GOV>; Candace Grace <Candace.Grace@la.gov>; MCOCommunications <MCOCommunications@la.gov>
Subject: UHC community case management agencies contract - PAST DUE
Importance: High

Good afternoon,

OBH has not received the contract/s that UHC has executed with the chosen community case management agencies that were due 11/19/21. See the highlighted portion in the email below. Please send the contract/s by noon tomorrow 11/30/21.

Kelley Francis, Ph.D.
Clinical Psychologist
Office of Behavioral Health - Louisiana Department of Health

From: Megan Davis Fontenot <Megan.Davis@LA.GOV>
Sent: Friday, November 12, 2021 11:09 AM
Subject: SOP and Supporting Documents - Due Friday, November 19th

Good morning,

We have reviewed the Community Case Management SOP and related deliverables submitted by the MCOs. There are still several areas that require revision, which are summarized below:

- CCM Strategy needs additional information for Healthy Blue, UHC and Aetna and advance directives need to be reviewed, as it is still included.
- OAAS Transition Assessment – This document must be submitted in a final form and include specific instructions for use. It's also not clear if this form is intended to replace the assessment form previously submitted.
- SOP – Documentation requirements were added to the SOP which are medical in nature and does not align with the scope of the CCM who should not be diagnosing or treating a member; SPOC contact information is needed

for United and Healthy Blue as previously requested; person-centered plan of care review timelines were revised; not clear when delegation of SPOC would occur; denial of CCM services by the CCMA is not appropriate.

- Quality Monitoring Tool Elements – there are still several places where OBH feedback was not addressed as previously provided.
- Progress Notes Template – please see suggested template labeled Community Case Management Contacts which addresses CCM contacts with members, health providers etc. In addition, this template addresses the expectation that CCMs collect monitoring information at least once per month and more often as needed (for example, the CCM should not collect this information at the beginning of the month only but not at the end of the month when a member's needs may have changed), but not necessarily at each contact/visit with the member.

Revised documents which fully addresses OBH's feedback are needed by **Friday, November 19, 2021**

If you would like to discuss any of the revisions or comments made, please choose a date and time that work best for you and we will arrange a meeting.

Monday, November 15th - 10:00 am – 1:00 pm or 2:00 pm – 3:00 pm
Tuesday, November 16th - 11:00 am – 3:00 pm
Wednesday, November 17th - 12:00 pm – 1:00 pm or 2:00 pm – 3:00 pm

In addition, please provide a copy of your agency's contract with community case management agencies by Friday, November 19, 2021. This information should be provided by each MCO directly to me via email.

Thanks,

Megan D. Fontenot
Megan D. Fontenot, LPC
Program Manager
Office of Behavioral Health
628 North 4th Street
6:30 A.M. – 3:15 P.M.
(225) 342-2067

LDH Flu Info: ***Roll Up Your Sleeves, Louisiana!*** (Fight the Flu website)
LDH Coronavirus Webpage: http://ldh.la.gov/Coronavirus/
OBH Webpage: http://ldh.la.gov/index.cfm/subhome/10
COVID-19 Behavioral Health Info: http://ldh.la.gov/index.cfm/page/3883
COVID-19 Provider Resources: http://ldh.la.gov/index.cfm/page/3880
Resources for OTPs: http://ldh.la.gov/index.cfm/page/3887
LDH Opioids Website: http://ldh.la.gov/index.cfm/subhome/54